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A STUDY TO IDENTIFY THE EXTENT OF RETIREE KNOWLEDGE OF CHAMPUS AND MEDICARE BENEFITS/LIMITATIONS

A Graduate Research Project

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I. INTRODUCTION

Background Information

The term placement problem is commonly being applied to many patients in acute care hospitals. Indeed, this problem is often charted as a diagnosis. Patients so labeled are a source of frustration for hospital personnel and a cause of contention between families and hospital staff. A "placement problem" characterizes a patient who no longer needs definitive medical care in an acute care facility, but cannot be discharged because of the lack of family support mechanisms or the patient's inability to pay for the medical care that may be required to subsist outside of the hospital. Often these financial difficulties stem from a lack of individual or family health care planning and inadequate supplemental insurance coverage. An additional contributing factor is that our present medical care insurance systems for reimbursement, both public and private, encourage the use of acute care facilities and personnel, although a less intensive delivery system would provide an adequate level of care.[1]

Placement problems are becoming more prevalent and complex within both public and private health care delivery settings. An unprecedented growth in the number of persons over age 65 is impacting on institutional medical care workload, resulting in increased lengths of stay and forcing health care management to address considerations for aftercare. For example, a growing number of the inpatients in military medical treatment facilities requiring discharge planning are geriatric patients. Many of these geriatric patients require continued medical care such as nursing homes and other extended care modalities. Unfortunately, while the demand for these services is steadily increasing, many communities are experiencing a shortage of nursing home beds and providers of custodial care services.[2]

In the military hospital setting, discharge planning was instituted to manage these placement problems efficiently. However, the ability to carry out these responsibilities effectively has been limited by two factors: (1) rising health care costs and (2) interagency coordination difficulties. The cost of nursing home care now consistently exceeds $1500 per month, making the funding of these health care costs prohibitive for most retirees.[3] Few retired persons have alternate resources or supplemental income to cover the differential for this type of nursing care.

Retired military patients under the age of 65 can apply under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for custodial services. Unfortunately, paperwork processing and the eventual payment through this system takes so long that many nursing homes refuse to admit CHAMPUS patients.[4] If there are no facilities in the community that accept CHAMPUS, the retiree may have no choice but to use that facility and provide reimbursement out of his/her own pocket.

Traditionally, one would look toward the family unit to assist in assuring support for the aged patient; however today most retired military patients stem from a nuclear family rather than from an extended family. Often, the children leave home, while the retiree and spouse take up residence in a community close to a military installation where they can take full advantage of retirement benefits. Consequently, little direct family support is available to many retired military patients.

Interagency coordination difficulties compound the problems already associated with financing alternate delivery systems. Successful placement of patients depends on open communication and smooth interaction between the discharge planning committee of the military medical treatment facility and civilian health care institutions. Each entity is governed by unique bureaucracies, with its own

policies and procedures. Invariably, discharge of the retired military patient requiring this type of assistance is delayed, sometimes unnecessarily obligating a hospital bed required by a patient who needs acute rather than supportive care.[5]

Because of the financial and administrative complexities of seeking medical care outside of the military sector, many retired military patients depend upon the federal health care system to provide all the medical services they may require. For many, this view includes providing nursing home and custodial care in addition to acute care. Few retirees realize that not only is this concept unrealistic during the present period of fiscal austerity, but also that it is a violation of federal law, under the Anti-Deficiency Act, for a military treatment facility to provide any type of custodial care. This problem will become even more serious as military health care budgets continue to diminish in line with federal spending cuts and as personnel shortages in many military medical specialties prevail.

Purpose of the Study

The health care coverage provided the active duty service member and his family provides little insight into the type of care available during retirement years. A pre-retirement briefing, which all retirees are required to attend prior to separation from active service, plus some federal publications which explain medical programs, and national news sources are their only means of learning about retirement medical care entitlements. These limited mechanisms do not adequately inform retirees about their health care benefit entitlements and the limitations to care imposed by CHAMPUS, the Veterans Administration, and Medicare. Misconceptions and a lack of knowledge regarding medical care entitlements may cause gaps, which in turn, may contribute to the failure to purchase additional health care coverage in the form of supplemental health care insurance.

The purpose of this study was to examine the relationship between the extent of the retiree's knowledge regarding medical benefits and the purchasing of supplemental medical insurance.

Statement of the Problem

To determine the extent to which a lack of knowledge of the medical benefits provided by CHAMPUS and Medicare among the retired military population results in procurement/nonprocurement of supplemental health care insurance.

Objectives

The objectives of this study were to:

1. Develop a questionnaire designed to evaluate the CHAMPUS and Medicare knowledge base of the target population.

2. Determine the minimum sample size of the above population.

3. Using this sample, conduct a survey of retired military members in the Letterman Army Medical Center (LAMC) catchment area to ascertain their knowledge base concerning CHAMPUS and Medicare benefits and limitations.

4. Evaluate the Preretirement Orientation Briefing at the Presidio of San Francisco to determine the extent of medical benefits information provided to service members about to retire from active duty.

5. Identify the medical care benefits and limitations governed by CHAMPUS and Medicare regulations.

Criteria

Research Criteria:

1. A level of significance of $\alpha = .05$ using a Chi-square test of independence was used to determine whether or not knowledge of medical benefits/limitations was independent of the procurement of supplemental medical insurance.

2. At least 60 percent of the questions on the military retiree health benefits questionnaire had to be answered correctly for a respondent to qualify as an informed beneficiary.

Assumptions

For the purpose of this study, it was assumed that:

1. Information regarding medical benefits and limitations provided by CHAMPUS and Medicare was available to retired military personnel.

2. CHAMPUS and Medicare regulations will not significantly change during the course of the study.

3. The sample used in this study was representative of the retired population in the LAMC catchment area.

Limitations

The limitations surrounding this research were as follows:

1. The survey was administered only to a sample of members of the retired military population in the LAMC catchment area.

2. Evaluation of the orientation process was focused on the active retirement orientation program at the Presidio of San Francisco.

Research Methodology

The research methodology for this study included the following:

1. A review of the present CHAMPUS and Medicare regulations.

2. Evaluation of the retirement orientation process to determine the quantity and quality of information provided the soon-to-be retired service member regarding retiree and beneficiary medical benefits/limitations. Evaluation was accomplished through observation and analysis of a preretirement orientation at the Presidio of San Francisco and by reviewing the retirement information packet provided prospective retirees attending these orientations.

3. With the assistance of Patient Administration Division consultants, a questionnaire was developed to ascertain the retirees' knowledge of medical benefits and coverage limitations. Included in the questionnaire was a section in which the respondents were asked to indicate the number of years that had elapsed since their retirement from the military service and whether or not they carry supplemental medical insurance for themselves and their dependents.

4. The draft questionnaire was administered in a pretest mailing to fifty retirees. The pretest results were then assessed to determine the relevancy of the questions and responses to the purposes of the study and whether or not modification of questions or format was necessary.

5. The sample size goal for the study, 150 retired military members, provided a large enough sample size to conduct a Chi-square test of independence.

6. Anticipating a 40 percent response rate, questionnaires were prepared and mailed to 400 retirees, randomly selected from a computer printout listing retirees residing within the LAMC catchment area. An example of the selection process was as follows: Since there are approximately 30,000 military retirees living in the San Francisco Bay area, a questionnaire was mailed to every 80th person listed

alphabetically on the printout.

7. The participants' responses were stratified into groups, based on five-year increments from the year of retirement, to assess whether or not knowledge of medical benefits/limitations declines as the length of time since retirement increases. Following stratification into groups, each response was scored. Responses with scores of 60 percent or better and those with scores below 60 percent were identified and recorded. Information on supplemental insurance was also recorded.

8. A chi-square test of independence was used to test whether knowledge of medical benefits/limitations and procurement/nonprocurement of supplemental insurance were independent. If the hypothesis-- that knowledge of medical benefits/limitations is independent of procuring supplemental insurance-- is rejected, it would be concluded that the two criteria of classification are not independent (Table 1).

TABLE 1 - Criteria of Classification Matrix

	Supplemental Insurance	No Supplemental Insurance
Knowledge		
Lack of Knowledge		

II. REVIEW OF THE LITERATURE

Placement problems resulting from inadequate personal planning and medical care financing shortfalls are not confined to the retired military population. With the explosive growth in the age groups beyond 65 and the spiraling costs of medical care, an increasing number of persons in our society are facing financial ruin as a result of out-of-pocket medical care expenses. This crisis is particularly acute for those members of our population who are elderly and limited by any or all of the following conditions: poverty, medical insurance coverage shortfalls, and extended dependence on the health care system because of a medical catastrophe.

In this portion of the research study I will first examine the geriatric demographic changes that will shape our future health care delivery systems. I will then review various public and private medical insurance programs in an attempt to identify the shortfalls in coverages contributing to the present financial plight of many of the aged. Finally, I will discuss various alternatives that can be developed to help alleviate the problems associated with financing long-term care.

Demographic Changes

The rapid growth in the aging population is projected to be one of the most influential forces shaping the health care delivery system well into the next century. According to the U.S. Bureau of Census, the number of Americans over the age of 65 will increase from 25 million in 1980 to 66 million by 2040. This increase represents a surge from 11 percent to 21 percent of the total population.[7]

Of even greater consequence is that the older population itself is aging. Those in the 75 and over age groups are the fastest growing segment of the American population. Although in 1982 less than 5 percent of the population was 75 or older, by 2030, almost 10 percent of the population is expected to be in that age category. By 2050, the proportion of the population 85 years and older is projected to grow from about 1 percent to 5 percent of the total population. The increases in the number and proportion of the very old are dramatic--from 123,000 in 1900, to 2.2 million in 1980, to a projected 16 million in 2050.[8]

These trends are alarming because, in general, persons in these upper age groups have the greatest need for social, income maintenance, housing, and health services. Because the incidence of chronic illness and disability increases with age, the sheer number of persons in the older age brackets will strain existing health care systems. Persons 65 and over use hospitals at 3.5 times the rate of those under 65, and length of stay increases with age for both men and women (9.0 days for the elderly, compared to 5.6 days for the younger age group). Using population projections from the U.S. Bureau of Census and American Hospital Association for the 12 month period ending October 1984, it is estimated that the 65-and-over age group has 414 admissions per 1000 population compared with 119 admissions per population for the younger age groups.[9]

As the number of chronically ill and disabled persons increases, those who are able to maintain independent subsistence will decrease. Unexpected changes in living arrangements, financial difficulties, and inability to perform self-care activities will proliferate among persons in this age bracket. These limitations highlight the increased need for health and social services among the elderly.

The proportion of elderly who might require some long-term care increases with advancing age. Estimates of the percentage of persons with a chronic condition that might partially limit or totally restrict the ability to carry on a major

activity are: (1) age 65 to 74, 41 percent; (2) age 75 to 84, 51 percent; age 85 or older, 60 percent. It is estimated that the absolute number of nursing home residents will increase by more than 54 percent by the year 2000 if current utilization rates are used to project future demand.[10]

Longer life expectancy and a lower mortality rate at every age for women contribute to an increasing ratio of women to men as age increases. For example, the ratio of men to women in 1960 was 82 to 100; in 1980 the ratio was 68 to 100.[11] Obviously, this factor will impact on the types of services needed to serve the increasing number of elderly women among the geriatric population.

Government Sponsored Health Insurance

In 1965, this nation's first venture into a national health insurance program began under the Medicare program. Medicare was designed to serve as the basic program to guard against the problem of rising health care costs for over 29 million older and disabled Americans.

Medicare comprises both hospital insurance (Part A) and supplementary medical insurance (Part B). Part A covers inpatient hospital care, care in a skilled nursing facility, and home health care; care in skilled nursing facilities has to be associated with a prior hospitalization to qualify for coverage. Part B covers physician services regardless of site of care, as well as hospital outpatient services, laboratory and diagnostic services, and services such as physical therapy and the purchase or rental of durable medical equipment.

Financed largely by a tax on earnings, Part A benefits are automatically and universally available at no additional premium cost to anyone 65 years or older eligible for Social Security retirement benefits. Part B benefits are not automatic, requiring the person to apply for the coverage and pay a low monthly premium.

Medicare does not provide benefits for routine dental care, hearing and vision services, or for medicines prescribed out of hospital. Home health care services are covered only if provided by skilled nurses, or for physical or speech therapy. Nursing home care, which in 1979 accounted for one-fourth of all medical expenditures by the elderly, is covered only after a hospital stay and only if skilled nursing or rehabilitation services are required. In fact, only 3 percent of nursing home services provided to the elderly in 1977 were reimbursed by Medicare.[12]

Even for covered services, Medicare requires deductibles, copayments, and coinsurance. Hospital inpatient insurance (Medicare Part A) requires a deductible equal to approximately the cost of one day in the hospital for stays up to 60 days per benefit period. Copayments are required for each additional inpatient day up to 150 days; these copayments are one-fourth of the deductible for each of days 61 to 90 and half the deductible for the remaining 60 days (the so-called "lifetime reserve"). Copayments for eligible stays in skilled nursing facilities amount to one-eighth of the hospital deductible per day after the first 20 days.[13]

Under the Supplementary Medical Insurance program (Part B), there is one annual deductible and a 20 percent coinsurance rate for most services. Physician coverage is limited to the Medicare allowable charge (this may be the actual charge for the service or the prevailing charge in the locality, whichever is lowest). Thus, in addition to the 20 percent coinsurance rate, patients are responsible for paying the difference between the Medicare reimbursement and the actual charge, unless the physician accepts assignment of the Medicare fee as full payment. Medicare program statistics show that reimbursements for physician services in 1977 averaged about 60 percent of total physician charges incurred by Medicare beneficiaries.[14]

The elderly poor and those on fixed incomes encounter problems trying to pay their deductibles, copayments, and other related Medicare related expenses. An analysis of current annual medical out-of-pocket costs has shown that persons over 65 years old in America paid 29.1 percent of their total medical care expenditures. This percentage is much higher than when the Medicare program was created 20 years ago.[15] Currently, 30% of Americans over age 65 do not have supplemental medical insurance coverage to help fill the gaps in medical coverage between what Medicare pays and the actual cost of medical services.[16] Thus, many patients have significant out-of-pocket medical expenses depending on the severity of illness or injury, and the duration of care received.

As many of our elderly have become acutely aware, Medicare was not designed to address the need for long-term care. Although it covers up to 100 days of skilled nursing home care, a copayment is required for all care beyond the 20th day. Users of the benefit have averaged about twenty-seven days of covered care per year. Medicare's claims criteria are often complex, restrictive, and subject to the individual judgments of claims reviewers, which vary substantially. Also, only a portion of all nursing home beds are certified for Medicare, limiting a beneficiary's access to covered care.

Medicare covers home health for patients needing part-time skilled nursing, physical therapy, or speech therapy; benefits have recently been expanded from 100 visits to unlimited visits. In practice, home health users, like nursing home users, receive nowhere near the limit of care that is covered, averaging only about twenty-three covered visits under the old rules. Under the new rules, some increase in use of home health care is expected.

Until the last few years, most of the elderly or disabled could rely on Medicaid to assist them with exorbitant medical costs when their Medicare benefits were exhausted or when their own resources were depleted to a level where they qualified

for Medicaid assistance. Unfortunately, many states, largely because of the tremendous pressure placed on the Medicaid budget by the growing need for long term care, have begun to seek ways to increase greater private financing. Many states have made their Medicaid eligibility requirements much more stringent thereby significantly decreasing the number of persons eligible for assistance.

Recent national policy has enabled states to find ways to shift costs to the families of patients who need long-term care. This includes family responsibility for an elderly patient's nursing home expenses and curtailing eligibility for public subsidy among potential recipients who transfer their assets to family members to become eligible for Medicaid. The burden of financing care is falling increasingly on the individual and the family, and there is usually no way for the family to reduce its liability.[19]

Medicare is in financial straits so severe that the government's Advisory Council on Social Security is calling for immediate reform. And Medicare reform is, indeed, urgent. The system is almost bankrupt, and attempts to contain its costs are unlikely to be effective. At the same time, payments to beneficiaries continue to decrease sharply: they now cover no more than half of the patients' expenses. Being sick is once again becoming a nightmare for the elderly poor. The original goal and first priority of Medicare was to eliminate this very threat.[20]

Private Insurance Coverage of the Medicare Population

In 1977, 66.6 percent of the population 65 years and over were covered by both Medicare and private insurance. One-fifth (20.4 percent) had Medicare coverage only, while 10.6 percent were covered by Medicare and Medicaid only. The balance (2.4 percent) were either uninsured (0.4 percent) or insured either by private insurance only, or by other sources (e.g., CHAMPUS/ CHAMPVA). Although most

private insurance and group insurance were more common among the employed. Insurance coverage increased with income, and decreased with age, particularly after age 75. Group insurance was more common among males than females. Private insurance was also more common among whites than nonwhites and among persons in excellent or good health, although these differences did not apply to the relative frequency of group coverage.[21]

Private insurance supplementing Medicare nearly always included coverage of hospital care; roughly 90 percent of privately insured Medicare enrollees also had coverage of inpatient physician services, including medical and surgical services. Private coverage of mental health care and physicians' office visits was held by approximately 6.0 percent of the elderly. Less commonly covered services included medicines prescribed out-of-hospital (40.6 percent) and dental care (4.1 percent).[22]

In relation to hospital care, roughly one quarter of primary insured Medicare beneficiaries with private hospital coverage were covered for the Part A deductible and all copayments as well as for expenses associated with a stay up to a year (215 days after Medicare Part A benefits were exhausted). Another half had full coverage of the Part A deductible and copayments, but not full coverage of hospital care after Medicare hospital benefits ended. One fifth had full coverage for only the Part A deductible, and the balance (5.8 percent) lacked full coverage of any Part A "gaps." As premiums increased, coverage of costs associated with a long-term illness requiring hospitalization increased as well. Also, persons with group insurance had more comprehensive hospital benefits than did persons with nongroup insurance, regardless of annual premium expense.

Insurance benefits for physician office visits, the most likely source of Medicare-related expense for the elderly, also depended on the level of premiums, but only for those with individually purchased insurance. Among primary insured

persons with nongroup insurance and coverage of physician office visits, 58 percent had coverage of the Part B coinsurance for physician's usual, customary,and reasonable charge. Another 33 percent had coverage of Medicare's 20 percent coinsurance in relation to Medicare's allowed charge. Among persons with group insurance, however, nearly 90 percent had coverage of the Part B coinsurance for the physician's usual and reasonable charge, and only 11 percent were restricted to Medicare's allowed charge.[23]

Because of lower administrative costs and high employer contributions, persons with group insurance typically obtained a higher range of benefits than persons with individual insurance coverage. Although coverage of skilled nursing facilities and the Part A deductible and copayments for days 61 to 90 did not vary with the source of insurance, Medicare beneficiaries with group coverage were more likely than persons who purchased their insurance directly to have outpatient care coverage that included diagnostic services, physician office visits, and prescribed medicines. They were also more likely than those with individual insurance coverage to have full coverage of expenses associated with a long hospital stay, including the Part A copayment for lifetime reserve days (85.4 percent compared with 69.7 percent) and the costs of up to 365 hospital days (59.4 percent compared with 13.8 percent). This was also observed for Part B coinsurance for inpatient and outpatient physician services, where those with group insurance were less often restricted to the Medicare allowable charge.[24]

In 1977, premiums for private health insurance held by Medicare beneficiaries totaled $3.8 billion, with a mean annual premium of $304 per primary insured person. The insured paid an average of 64.8 percent of these costs, current and former employers paid 31.9 percent, and the balance was paid by others, such as labor unions. Medicare beneficiaries insured under group policies had more than twice the total annual premiums of persons with nongroup insurance ($537 in comparison

with $201), but employers paid 58.1 percent of this expense on average. Thus, the out-of-pocket cost of private insurance for persons with group and individual insurance coverage was comparable ($196 compared with $197).

The comprehensiveness of private insurance coverage purchased by the elderly was partly related to the level of premium expense. While hospital insurance was an almost universal benefit at all premium levels, increases in premiums generally secured either supplementary coverage of outpatient services covered by Medicare (such as physician office visits) or coverage of services not covered by Medicare (such as prescribed medicines). At every premium level, persons with group insurance were generally more likely to be covered for services not covered by Medicare or with only restricted coverage, such as mental health services, than were persons with individual insurance coverage. Care in skilled nursing facilities was the exception.[25]

Although widely held by the Medicare population in 1977, private insurance was more prevalent for some groups of this population than for others. Overall, 20 percent of elderly Medicare enrollees lacked both private and public supplements to Medicare; this proportion rose to 25 percent among persons 75 years and older, among those with poverty or other low incomes, and among those in only fair or poor health. Even among the privately insured, benefits varied considerably by type of service, with more coverage and more generous benefits for inpatient care than for outpatient services such as physician office visits. Thus, more than 80 percent of elderly persons had some out-of-pocket liability for medical expenses, despite the fairly wide availability of private insurance and despite the fact that Medicaid covered ten percent of the elderly Medicare population who lacked private insurance.[26]

Employment-Based Health Insurance

Business corporations are important purchasers of medical care services, buying annually tens of billions of dollars worth of medical care on behalf of their employees. With the sheer force of its purchasing power, big business has become the second major force behind the federal government in precipitating change within the health care delivery system. Their influence has significantly impacted on the delivery, utilization, and pricing of medical care services and inadvertently reinforced the government's regulatory efforts to control hospital costs via Diagnostic Related Groups (DRGs).

The degree of health coverage in most employment-based health insurance plans is dependent upon the type of industry (e.g., manufacturing, service, trade, construction). Each has a specific range of health insurance protection and cost-sharing requirements affecting both professional and craft workers and their dependents. In this regard, full and comprehensive health coverage was used to attract highly skilled professional workers, or resulted from longstanding union bargaining agreements that were made to reduce the cost of health insurance for craft and technical workers. Workers employed in firms that required lower skilled or nonunionized workers were subject to less comprehensive health insurance plans, with a larger degree of cost sharing.[27]

Recently, in an effort to bring spiraling operating costs under control, most corporations offering extensive employee health care benefits are attempting to shift a greater portion of the financial burden for health services back onto the employees. The corporations are accomplishing this objective by increasing the copayments and/or deductibles associated with various reimbursement mechanisms or by requiring employees to pay part of the premium for their health insurance benefits.

Many firms are expanding the health care coverage alternatives to other than insurance based programs, by affording their employees the opportunity to participate in a Health Maintenance Organization (HMO) or to elect medical care in local health care facilities under Preferred Provider Organization (PPO) agreements. Some enterprising firms are even creating their own health care delivery systems or investing in promising health care markets to gain an element of control over the costs of delivering health care to their beneficiaries.

Unfortunately, even with the vast number of persons covered by employment-based insurance programs, and the proliferation of new health care delivery alternatives, an increasing number of persons in American society are losing access to these health related support systems. Unemployment in recent years had been the highest since the Great Depression. With unemployment, the American worker loses not only a job but also health insurance protection. As unemployment rates rise and the numbers of the uninsured grow, fewer and fewer resources are available to fill the gaps in health care coverage. Major reductions in funding for health services for the poor and uninsured have been made in the last year, and further reductions are likely. Periodic economic recession, high unemployment rates and declining sales revenues are depleting the fiscal resources of state and local governments. Their ability to offset federal cutbacks seems limited. Nor can the private sector be expected to bridge this gap. Decreasing revenues as a result of federal capitation programs and spiraling operational costs have caused most private health care treatment facilities to become increasingly entrepreneurial business endeavors, with little room for charitable actions.[28]

Repercussions of these large numbers of persons without health insurance coverage are being felt in public and private hospital and clinical settings nationwide. As a result, many private hospitals are transferring their nonpaying patients to public general hospitals. Public general hospitals rely on publicly

financed health insurance patients for payment, and only 12 percent of their patients are private paying patients. As long as these fiscal austerity issues continue, the problem of medical protection for the growing numbers of uninsured consumers will remain a constant concern.[29]

Long-Term Care Financing Alternatives

Examination of our country's future demographics and the various programs described above shows that existing systems to finance medical care, particularly long-term care, leave significant coverage gaps in medical costs which many of the elderly are unable to pay. Health care professionals, researchers, and others are just now beginning to consider the alternatives to the present ways of financing long-term care. Most, however, generally agree that a combination of efforts of federal and state governments, providers, and insurers is needed so that no one entity ends up paying the whole bill. Foremost in the efforts to investigate health care financing alternatives are Medicare reform and increased reliance on private financing mechanisms to support medical insurance and benefit programs.

Medicare Reform

Ideas for Medicare reform have come from various segments of the industry. Peter F. Drucker, noted author of management theory, has suggested that the Congress convert Medicare into "catastrophic illness insurance." Under this plan, each person would pay health care expenses up to a certain percentage of pre-tax income, for example 15 percent, and any health care expenses above that figure would be paid in full by Medicare. The truly poor then would have full or almost full health care reimbursement. The 80 percent with pre-tax incomes above the poverty line would

normally pay their own health care expenses, which typically run below 10 percent to 12 percent pre-tax income in any given year. In the event that a person above the poverty line had an exceptional catastrophic event (an increasing likelyhood with advancing age), Medicare would reimburse all costs above the established percentage of pre-tax income.[30]

The American Hospital Association Intercouncil Working Party on Health Financing Reform considered a variety of Medicare reform approaches and made a number of suggestions for both expenditure reform and revenue reform.

Regarding expenditures, the group recommended that Medicare (1) raise the eligibility age for benefits by tying it to age of eligibility for Social Security benefits; (2) design fair and workable prospective pricing systems, not necessarily DRG based, for nonacute, non-inpatient, and currently exempted services; (3) establish a single reasonable, realistic, front-end annual deductible that would apply to all covered services used by beneficiaries and provide protection against the costs of catastrophic illness; and (4) develop a preferred provider option and provide incentives to beneficiaries to enroll in a Medicare Health Maintenance Organization (HMO), Competitive Medical Plan (CMP), or preferred provider arrangement.[31]

The group decided that these expenditure reforms would be inadequate unless accompanied by revenue reforms. Suggested revenue reforms centered primarily on increasing or removing the taxable income limit on the FICA Medicare hospital insurance component; establishing a premium contribution by beneficiaries, through the personal income tax system, that would be tied to income level and that would go into the Medicare trust fund; and contributing to the trust fund excise taxes on certain products or services that adversely affect one's health and increase medical costs, such as alcohol and tobacco.[32]

Another reform approach that has been considered to address providing long-term care financing can be found in HR 6145, the Medicare Long-Term Care Act of 1982. This bill proposed to establish a Medicare, Part D, which would support long-term care for enrollees, provided that the enrollee paid a monthly premium. Proposed benefits in this program include home health care, homemaker services, nutrition services, long-term institutional care, day care and foster home services, and community mental health outpatient services.[33] This bill has not made it through the legislative process because it would require additional appropriations from public sources to cover expenses incurred. There is little chance of it being passed with the present administration's emphasis on holding the line on federal spending.

Private Payment for Long-term Care

Although efforts are being made to evaluate and change our public support programs to fulfill the needs of the beneficiary population, it has become quite obvious that the problems inherent to our large bureacracies and resource limitations will prevent the government from taking care of everyone's health care needs. It is imperative that nonpublic payment sources for long-term care be explored and developed to ensure that those persons requiring services can obtain them. The nonpublic, or private, payment sources for long-term care activities that will be explored include: private donations, private insurance, self-paying individuals, community concepts, and family contributions.

Private Donations

Many important factors influence who gives how much in private donations. Among these factors are income level, corporate profits, economic well-being,

the inflation rate, the stock market and the present tax structure. A study by R. I. Lipp has shown that the individual American is, in fact, the most likely source for increased funding for nonprofit institutions. Individuals are also forecast to be the largest source of funding, and the most dependable, compared with corporations, bequests, or foundations.[34]

Contributions to health care organizations and hospitals increased from $596 million in 1955 to $8.4 billion in 1982, approximately a 10 percent average annual rate of increase. One half of these contributions come from private donors, as opposed to bequests and national foundation sources. Certainly, increases in private donations could reduce some of the costs that are currently paid by public sources. Nonprofit organizations providing health care services need to be aware of the resources available to them through these individual donations and create operational programs to pursue these resources actively.[35]

Private Insurance

The most underdeveloped source of private payment for long-term care services is that of private insurance. Insurance companies have consistently avoided the long term care arena because of doubts about its profitability and because long-term care encompasses so many different kinds and levels of medical services. The structure of insurance policies for long-term care services could take several forms. One possibility would be to extend current group policies obtained through the place of employment. A higher premium would have to be charged, but the enrollment of a heterogeneous group would reduce the overall risk to the insurance companies. Options for participating in the same group plan after retirement (at the individual's expense) could be built into the policy. Additionally, the copayments required for acute or long-term care could vary in percentage or deductibles, again reducing the risk to the insurer.

Non-medical, long-term care services should be included in such a policy, or a situation could arise in which patients would opt for more intensive service than is needed simply because they have insurance coverage, a problem that exists in the Medicare program today.[36]

Another approach already used by some private insurance companies, would be to integrate long-term care services into health maintenance organizations. Such services could be offered as an optional package, or they could be incorporated into current benefits. The necessary increases in premiums, could vary among actuarial classes. In addition, copayments by recipients could be required, with a ceiling to protect them from catastrophic losses. Long-term care services could be operated and provided by the HMO or contracted out on a competitive basis.[37]

The ideal position for private insurance policies would be to implement the life-care concept. Then all health-related needs, ranging from acute hospital care to the more social types of care, would be incorporated into one policy. The continuum of care resulting from such a structure would prove exceedingly beneficial to persons subscribing to the policy.[38]

Self-paying Individuals

Self paying individuals represent another payment source, with great potential for increasing the level of financial support for long-term care. The concept of an individual retirement account (IRA) set up specifically for health care services or long-term care is a method of increasing the availability of private funds for such services. The proposed form and structure of this type of account vary, but typically these savings provide tax benefits to the owner of the account, with penalties for early withdrawal or use for services not entailing long-term care.

Privately funded pensions could also contribute to these accounts. Contributions by employers or pension funds should not replace savings by individuals, but should serve to augment and motivate savings. A matching dollar contribution or other incentive structure could be devised.[39]

Community Concepts

Another approach to the financing of long-term care is the concept of life care. A life-care community, or comprehensive continuing care community, provides the full range of long-term care services to its residents as needed. Many elderly persons are interested in this type of an organization because it guarantees availability of services in a convenient fashion, with the added advantages of having a peer group of fellow residents, while still maintaining an independent lifestyle.

A significant drawback to these lifecare communities is their high cost. One possible financing mechanism for such communities is the reverse annuity mortgage. Most of the elderly are homeowners. A reverse annuity mortgage would guarantee a fixed-life annuity, or yearly income, in exchange for the property deed, thereby increasing the cash flow of an individual or couple and bringing the life-care community into an affordable price range.[40]

A reverse annuity mortgage could also be useful for the elderly who wish to remain in their homes but require long-term care. The income from the reverse annuity mortgage could be used for supplementing other income sources as well as for purchasing in-home, long-term care services. The title to the home would be transferred only after the persons moved or died. This approach would allow the elderly to maintain an independent lifestyle in their present community, an alternative that may be preferable to relocating in a retirement community.

Family Contributions

A significant portion of non nursing home, long term care services is provided directly by family or friends. If public financing of long term care services is to be kept as low as possible, it is important to maintain the informal support mechanism.

Proposals have been made that would provide incentives for family members to provide care for their elderly, disabled relatives, e.g. tax credits could be given even if the disabled relatives were not living with them. Contributions by family members could also be required before the individual could receive public funds for long-term care.

Regardless of what future Medicare and Medicaid reforms are enacted, it is imperative that private financing mechanisms be developed to insure that the provision of health care services to our elderly population is maintained. Donations, private insurance, and creation of incentives to encourage greater family and individual support of financing health care must be pursued if we are to meet this objective.

FOOTNOTES

[1]R. Fisher and M. Zorzitto, "Placement Problem: Diagnosis, Disease or Term of Denigration?" Canadian Medical Association 129 (August 15, 1983): 331.

[2]Wayne St.Pierre, "Discharge Planning and the Turnip Syndrome," unpublished paper prepared at Letterman Army Medical Center, San Francisco, California, 1983: p. 2.

[3]Ibid., p. 3.

[4]Ibid., p. 1.

[5]Ibid., p. 1.

[6]Ibid., p. 1.

[7]Riffer, Joyce, "Elderly 21 Percent of Population by 2040," Hospitals, 59 (5) (March 1, 1985): p. 41.

[8]Ibid., p. 42.

[9]Ibid., p. 42.

[10]Jennings, Marian C. and Krentz, "Private Payment for Long-Term Care: the Untapped Mechanism," Topics in Health Care Financing. 10(3) (Spring 1984): p. 3.

[11]Ibid., p. 1.

[12]U.S., Department of Health and Human Services, Private Health Insurance Coverage of the Medicare Population, National Center for Health Services Research, (April 16, 1984): p. 2. Hereinafter referred to as DHHS, Private Insurance.

[13]Ibid., p. 3.

[14]Ibid., p. 3.

[15]Hester, Ronald D. "Catastrophic Medical Protection: A Plan for Sharing Excessive Costs." Urban Health 10 (November-December 1982): p. 33.

[16]Hester, et al., p. 34.

[17]Meiners, Mark R., "The Case for Long-term Care Insurance." Health Affairs 2 (Summer 1983): p. 58.

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[19]Meiners, Mark R., and Gollub, James O., "Long-term Care Insurance: The Edge of an Emerging Market." Health Care Financial Management (March 1984): p. 58.

[20]Drucker, Peter F., "Drucker: Total Restructuring is Required to Save Medicare, Serve Social Justice," Hospital Management Quarterly (Winter 1983): p. 19.

[21]DHHS, Private Insurance, p. 11.

[22]Ibid., p. 11.

[23]Ibid., p. 12.

[24]Ibid., p. 11.

[25]Ibid., p. 12.

[26]Ibid., p. 11.

[27]Hester, et al., p. 33.

[28]Ibid., p. 34.

[29]Ibid., p. 34.

[30]Drucker, et al., p. 19.

[31]Traska, M.R., "Medicare Reform Details Are Still Vague," Hospitals, Vol. 59, no. 5 (March 1, 1985) p. 64.

[32]Ibid., p. 64.

[33]Jennings, et al., p. 10.

[34]Ibid., p. 14.

[35]Ibid., p. 14.

[36]Ibid., p. 16.

[37]Ibid., p. 17.

[38]Ibid., p. 17.

[39]Ibid., p. 18.

[40]Ibid., p. 18.

[41]Ibid., p. 19.

III. DISCUSSION

A validated questionnaire survey (Appendix A) was distributed to 400 military retirees in the LAMC catchment area. The sample population was randomly selected from a computerized retiree address listing obtained from the Presidio of San Francisco Retirement Services Office. One hundred eighty-six questionnaires were completed and returned in time for inclusion in the findings. Three of the returned surveys were incomplete and were excluded from the study. The response rate of questionnaires was 46 percent.

The questions on the survey were formulated from information obtained from literature resources available to military retirees at pre-retirement orientation briefings and through installation services that support the retiree population. The questionnaire contains 12 multiple choice questions, each having only one correct response. A correct response to at least eight questions (60 percent or greater) demonstrated adequate knowledge of Medicare and CHAMPUS benefits/limitations. Therefore, eight or more correct responses was considered a satisfactory score and seven or less correct responses was considered a poor score on the survey.

Respondents were also requested to indicate the number of years that had elapsed since their retirement from military service, and whether or not they had purchased any private health care insurance to supplement their Medicare or CHAMPUS coverages.

Preretirement Orientation Briefing

On 28 January 1985, the Retirement Services Office, Presidio of San Francisco, conducted its semiannual Preretirement Orientation Briefing. The author's interest in attending this briefing was to review the information provided to prospective retirees regarding future entitlements and limitations to medical benefits.

The presentation on the CHAMPUS program was highly informative, with particular emphasis placed on the need for retirees to consider purchasing supplemental health care insurance. The presenter reinforced the importance of purchasing supplemental insurance by discussing the 25% copayment required for all CHAMPUS reimbursements for care provided retirees and dependents. Other factors stressed included the importance of enrolling family members into the Defense Eligibility Enrollment System (DEERS), keeping family identification cards current, and that retirees are entitled to care within military medical treatment facilities only on a third priority basis, after active duty members and their dependents. Also covered were policies governing use of non-availability statements, and that insurance policies for working spouses often can provide supplemental health insurance coverage for the retired military member. The outpatient service deductible of $50.00 per visit $100.00 maximum for each family/year was also discussed. CHAMPUS was described as a "state of the art" health insurance program that has small deductibles and copayments and very few limitations on the type of medical care services covered.

In a brief presentation on Medicare benefits, the presenter explained that the program was available to persons 65 years or older and to persons suffering from chronic renal failure. Eligibility requirements to qualify for Part A coverage and the costs associated with participating in Medicare (Part B) were also

addressed. No information was given on Medicare deductibles and copayments; nor was any information provided on the limits of nursing home or home care support services covered under the Medicare program. Thus, strong arguments for purchasing supplemental insurance were not brought up for consideration.

The Veterans Administration presentation was poorly organized and lacked substance. The presenter briefly touched upon educational benefits, death benefits, disability benefits, and applying for dental care coverage within 90 days of retirement. The sole reference to medical care was that only the retiree is eligible for care in VA facilities; family members unequivocably must be treated elsewhere. Very little information in this portion of the orientation encouraged attendees to seek supplemental health care insurance.

Various pamphlets, fact sheets, magazines, and other literature resources focusing on retiree benefits and programs were available to retirees, to reinforce and supplement information given during the presentations. Material pertaining to retiree health benefits included: The Retiree Bulletin (Vol.2 July-Dec 1984); Uniformed Services Journal (January-February 1985); VA Pamphlet 27-82-2 (Revised June 1984), entitled "A Summary of Veterans Administration Benefits"; U.S. Department of Health And Human Services Social Security Administration Publication No. 05-10029, entitled "If You Become Disabled"; Federal Benefits for Veterans and Dependents, (IS-1 Fact Sheet, January 1,1983); CHAMPUS Handbook 6010.46-H; DOD CHAMPUS Fact Sheet-11 (1983), entitled "Military Care CHAMPUS, Your Benefits In A Nutshell"; DOD CHAMPUS Fact Sheet-12 (1983), entitled "CHAMPUS How to File a CHAMPUS Claim"; Army Echoes (October/December 1984 Volume XXVIII, Issue 4"; and The Retired Officer (January 1985).

These publications and information resources provide more explicit data on the CHAMPUS, Medicare, and VA benefit programs. Program structures, eligibility requirements, entitlements, regulatory limitations, and points of contact to

obtain additional information are addressed in these resources. A thorough review of these resources, provides a working knowledge of retiree medical benefit entitlements and a better understanding of the limitations that can affect the retiree's future health care security.

Relationship Between Knowledge of Medical Benefits and Securing Supplemental Health Care Insurance

Table 2 provides a review of the survey results based on whether the respondent did or did not carry supplemental health care insurance and the results of the Chi-square statistical analysis. The Chi-square test for independence supports the null hypothesis that knowledge of medical benefits/limitations, and procurement/nonprocurement of supplemental health insurance, are independent of each other.

TABLE 2 - Supplemental Insurance Coverage vs. Total Score Percentages

		SCORE		
		Poor	Satisfactory	Total
Supplemental Insurance Coverage	Yes	32.3%	13.4%	45.7%
	No	40.9%	13.4%	54.3%
	TOTAL	73.1%	26.9%	100.0%

Statistic	Value	D.F.	Prob.
Chi-square Independence Test	.519	1	.4752

The Critical Value is 3.841

Table 3 delineates the observed frequency of responses obtained from the survey. Simple data analysis shows there was little disparity in performance on the questionnaire between those that carried supplemental health care insurance and those that did not carry the insurance.

Table 3 - Supplemental Insurance Coverage vs. Total Score Observed Frequency

		Score		
		Poor	Satisfactory	Total
Supplemental Insurance Coverage	Yes	60	25	85
	No	76	25	101
	TOTAL	136	50	186

Survey results did disclose that an alarming percentage of retirees appear to have very little knowledge of Medicare and CHAMPUS regulations and practices (Table 4). Seventy-three percent of retirees completing the survey answered 7 or less of the 12 questions correctly. Nearly one-third of those surveyed were not able to answer any more than 4 of the 12 questions accurately and nearly 5 percent of the 186 respondents were unable to answer any of the questions in the survey correctly.

Table 4 - Score on Questionnaires vs Percentage of Respondents

		Percentage of Respondents	Cumulative Percentage
	0	4.9%	4.9%
	1	2.1%	7.0%
	2	3.8%	10.8%
	3	8.1%	18.9%
	4	12.3%	31.3%
	5	12.9%	44.2%
SCORE	6	13.5%	57.6%
	7	15.6%	73.2%
	8	8.0%	81.3%
	9	5.4%	86.7%
	10	7.5%	94.2%
	11	2.7%	96.9%
	12	3.2%	100.0%

The high percentage of retirees failing to do well on the survey may demonstrate that few are using available resources in developing plans for future health care needs, or that the perceived threat of possible catastrophic medical costs is not strong enough to generate personal interest in understanding federal health care programs for which they are eligible. This lack of planning was further

substantiated by the fact that 54.3 percent of respondents in the survey did not carry any type of health care insurance to supplement their CHAMPUS or Medicare coverage.

Lack of adequate insurance coverage has three major consequences: (1) It may contribute to needless pain, suffering, disability, and even death because it may prevent the retiree or family member from seeking care rather than assuming possible financial debt because of deductibles or copayments; (2) it places a financial burden on the retiree and his family to pay a portion of unexpected medical care costs; and (3) it places a financial and resource strain on federal hospitals, physicians, and other health care providers who attempt to provide care to these individuals even though they may be abusing the system.

Analysis of Responses Stratified by Years from Retirement

Those retirees on the two extremes of the retirement years spectrum had the most difficulty with the survey. Ninety-two percent of those retired five years or less and 100 percent of those retired more than 40 years did poorly on the survey (Table 5).

Table 5 - Years From Retirement vs. Percent of Row Score Totals

		Score		Distribution of
		Poor	Satisfactory	Responses
Years Since Retirement	None	.0%	.0%	0
	0-5	91.7%	8.3%	12
	5-10	75.0%	25.0%	20
	10-15	78.8%	21.2%	33
	15-20	75.0%	25.0%	48
	20-25	62.8%	37.2%	43
	25-30	57.1%	42.9%	7
	30-35	85.7%	14.3%	7
	35-40	50.0%	50.0%	10
	GTER 40	100.0%	.0%	6
	TOTAL	73.1%	26.9%	186

Part of this poor performance by the two groups may be attributable to other stressors that characterize their particular states of life. For example, new retirees frequently are overwhelmed by the many adjustments that characterize this period, including responsibilities of relocating their families, competing for new jobs, and, in most cases, adapting to a new lifestyle.

Once the retirees enter a second career, many are covered by employment-based health care programs. Additionally they may be eligible for health care benefits through the health care plans of their working spouses.

Persons who have been retired for more than 40 years are likely to be so inundated with problems associated with day to day living and chronic health care problems that they become frustrated and careless about health care planning. The public and private health insurance programs associated with medical care are so complex, that the retirees have given up trying to understand them or keeping abreast of the many changes characteristic of health program regulations.

Fifty percent of respondents retired for 35-40 years and 42.9 percent of respondents retired for 25-30 years performed satisfactorily on the survey. The fact that some of these individuals are approaching, or have just passed 65 years of age, may prompt a keener interest in personal health care planning, with the result that they are actively seeking information on the Medicare and CHAMPUS programs. Basic familiarity from more frequent use of these reimbursement mechanisms with advancing age may have also contributed to the increased number of correct responses in these age groups.

Analysis of the Individual Survey Questions.

In addition to the overall performance of the sample population, individual questions on the survey were examined to identify specific Medicare and CHAMPUS

program areas that are not well understood within the beneficiary population (Appendix B). The most apparent misunderstanding was in the area of the deductibles and copayments that are part of the Medicare and CHAMPUS programs. Only 39 percent of the sample population were aware that there is a yearly deductible of $50 for one person, or $100 maximum for a family receiving medical outpatient care through CHAMPUS. Only 30 percent of respondents were aware that they would have to pay 25 percent of the costs associated with CHAMPUS outpatient care treatments for a retiree or any family members.

Similar results were evident in questions concerning Medicare deductibles. For example, only 29.5 percent of respondents knew that there was a $356 deductible for inpatient services rendered in 1984 for Medicare (Part A) coverage. When asked about the 1984 inpatient hospital coinsurance amount that must be paid for each day of hospitalization associated with Medicare (Part A) coverage, only 18 percent realized that they were responsible for $89 per day from their own resources.

This lack of knowledge of deductibles and copayments is alarming because it affects the costs that families must pay for care; if consumers do not understand their insurance benefits, their decisions about medical care use may be based on incorrect estimates of the costs they will ultimately incur. Ambiquity in this area may be another reason these families either do not purchase insurance to guard against significant out-of-pocket expenses or purchase too much or too little insurance.

A second area of concern involves program eligibility for various services. Forty-one percent of the sample population did not know that eligibility for care in a DOD treatment facility was contingent upon availability of space and facilities and the capabilities of the professional staff. Forty three percent of the sample population did not know that eligibility for Medicare excludes one from eligibility for CHAMPUS benefits. Within the Medicare program, 41 percent of the respondents

were unaware that domiciliary care is not covered under Medicare Part A or Part B, and few respondents knew the Medicare inpatient reserve days available to them if they require extended inpatient care. Sixty-eight percent of the sample population did not know the correct number of reserve days associated with this program.

The significant number of retirees who appear to be unfamiliar with eligibility aspects of Medicare and CHAMPUS regulations is disconcerting. The results of the survey suggest that a high percentage of retirees do not understand the limits governing their access to various elements of the military health care system and to services available to them under federal insurance programs. Because of these misunderstandings many may fail to plan adequately for total health care needs of themselves and their families. As an example, the discharge planning program at LAMC is consistently restrained from carrying out its responsibilities because many retirees are unable to pay for care out of the military acute care hospital setting.

IV. SUMMARY AND RECOMMENDATIONS

Summary

The intent of this paper has been to determine the extent to which a lack of knowledge of medical benefits provided by CHAMPUS and Medicare among the retired military population results in procurement/nonprocurement of supplemental insurance. Based on the results of a 12 question survey, completed by 186 retirees in the LAMC catchment area, a statistically significant dependent relationship between knowledge of medical benefits and whether or not retirees purchased supplemental health care insurance could not be shown.

However, the total frequency distribution of individuals who failed to achieve a 60 percent correct response rate on the questionnaire (73 percent of the sample population) showed that an alarming percentage of military retirees appear to have very little knowledge of Medicare and CHAMPUS regulations and practices. In particular, the respondents had difficulty answering questions which addressed Medicare and CHAMPUS deductibles and copayments and many respondents were unfamiliar with the eligibility limits imposed by Medicare, CHAMPUS, and the military health care system.

The health care coverage provided to the active duty service member and his family provides little insight into the level of care they can expect upon retirement. The military does provide a mandatory preretirement orientation briefing for all personnel about to retire from the service, but it does not sufficiently address personal and family health care planning issues.

Information abounds on federal health care programs containing specifics on eligibility requirements, the benefits provided, and limitations to medical care coverage. These information resources are made available to the service personnel approaching retirement, who must then investigate these resources in order to

understand the future health care coverage that will be available to them and their families during retirement. It is apparent from this study that many military retirees fail to accomplish this type of investigation. As a result, many retirees do not understand the details of federal health care programs and that it is essential that they procure some form of supplemental health care insurance to protect themselves from possible medical care catastrophies. Almost 55 percent of respondents did not carry any type of private health care insurance to supplement their CHAMPUS or Medicare coverage.

Recommendations

The present military health care systems and federal health care insurance programs are under extreme scrutiny because of the significant amount of tax dollars required to operate these programs. Those who are responsible for administering these programs as well as the beneficiaries themselves, must take positive actions to use available health care resources efficiently or face the real possibility that some of these benefits will be removed, reduced, or altered, thereby forcing the beneficiary to assume more of the financial burden.

The degree to which the retiree designs a personal and family health care plan and efficiently uses health care benefits are key factors in determining whether we can use scarce medical resources in the federal health care sector to better advantage. Those of us in the military health care system have a monumental public relations and education responsibility if we are dedicated to assisting retirees in meeting these objectives. All military public information services; the Retirement Services Office, and personal communications with beneficiaries should be directed to inform our beneficiaries how to use available medical services wisely.

The following recommendations are offered: First, all retirees who do not have supplemental insurance, either for CHAMPUS or Medicare, should be encouraged to purchase it.

Second, all retirees not currently enrolled in the Defense Enrollment Eligibility Reporting System (DEERS), should be assisted in doing so. This system ensures that our health care system is being used only by eligible beneficiaries and provides a much needed data base for the Department of Defense (DoD) to allocate scarce medical resources.

Third, retirees engaged in a second career, or who have working spouses who have health insurance benefits that cover family members, should be encouraged to use those health benefits first, before using the military health care benefit. This would free up medical resources for fully retired persons and dependents of active duty service members. CHAMPUS could then be used to supplement any benefits not covered by the employer-provided plan.

Fourth, retirees or family members eligible for Medicare of VA benefits should use those systems first before using CHAMPUS. Both are excellent programs and operate at less cost to the government than receiving the same care through CHAMPUS.

Fifth, all retirees and eligible family members should be urged to be prudent users of their health care benefits. They should not hesitate to question why a service cannot be provided in an outpatient basis or in an ambulatory mode, rather than as an inpatient. Excessive diagnostic testing or recurring mistakes necessitating further testing should be questioned and investigated. Patient assistance offices or the Inspector General can help to resolve legitimate abuses in our systems.

The retiree and family should be encouraged to perform very careful audit checks on the care they receive under the CHAMPUS program. They should verify that they actually received the care stated on their CHAMPUS bills and refer all abuses to the Inspector General or Patient Administration Division in the military medical treatment facility responsible for payment.

Finally, retirees not receiving the type of health care services to which they believe they are entitled should have open channels of communication to hospital commanders and federal administrators in the Medicare and CHAMPUS systems. Feedback from beneficiaries is essential if we are to improve our military health care system, fine tune it and provide the service to which beneficiaries are entitled.

APPENDIX A

MILITARY RETIREE HEALTH BENEFITS QUESTIONNAIRE AND COVER LETTER

MILITARY RETIREE HEALTH BENEFITS QUESTIONNAIRE

Please place an X in the box beside the statement which best answers the question being addressed.

A. How long has it been since your retirement from the military service?

[ ] 0-5 years
[ ] 5-10 years
[ ] 10-15 years
[ ] 15-20 years
[ ] 20-25 years
[ ] 25-30 years
[ ] 30-35 years
[ ] 35-40 years
[ ] Greater than 40 years

B. Do you presently purchase any type of medical insurance (other than Medicare, Part B) to provide additional protection against increasing health care costs?

[ ] Yes (If yes, what type?_____)
[ ] No

The questions below were formulated to assess your present knowledge base of the medical benefits/limitations which are part of the Medicare and CHAMPUS programs. Please select the single best answer for each question and mark an X in the block corresponding to that one answer.

1. Retirees and their dependents are authorized care in Uniformed Services facilities regardless of their eligibility for Medicare subject to: (select only one)

[ ] Demonstrating that they are financially unable to defray the cost of care elsewhere.

[ ] Living within a 40-mile radius of the military installation where the health care facility is located.

[ ] Availability of space and facilities and capabilities of the professional staff.

[ ] Meeting the same qualifications which are required for CHAMPUS benefits.

2. If you are eligible for Medicare (Part A) coverage and are a retiree, a survivor, or a dependent of a retiree you are: (select only one)

[ ] Still eligible for CHAMPUS benefits.
[ ] Not eligible for CHAMPUS benefits.

3. Which one of the following groups of individuals is not eligible for CHAMPUS benefits? (select only one)

[ ] Children of active duty members.
[ ] Dependent parents or parents-in-law.
[ ] Spouses of retirees.
[ ] Unremarried widowers and widows of deceased active duty members and deceased retirees.
[ ] Children of retirees.

4. What is the yearly deductible amount which must be paid by the patient or family associated with CHAMPUS medical coverage for outpatient care? (select only one)

[ ] There is no deductible.
[ ] Yearly deductible of $25 for one person or $50 for a family.
[ ] Yearly deductible of $50 for one person or $100 for a family.
[ ] Yearly deductible of $100 for one person or $200 for a family.

5. Retired military families pay or cost share what percent of CHAMPUS outpatient care costs? (select only one)

[ ] 5 percent
[ ] 10 percent
[ ] 15 percent
[ ] 20 percent
[ ] 25 percent

6. Medicare is a federal health insurance program for people age 65 or older, people of any age with permanent kidney failure, and certain disabled people. Medicare is divided into two parts, which are: (select only one)

[ ] Outpatient insurance and inpatient insurance.
[ ] Hospital insurance and medical insurance.
[ ] Institutional insurance and physician insurance.
[ ] Hospital insurance and community health program insurance.

7. Which one of the following services is not covered under either Part A or Part B of Medicare? (select only one)

[ ] Doctor's services.
[ ] Outpatient hospital services.
[ ] Home health visits.
[ ] Domiciliary/custodial care.
[ ] Inpatient hospital care.

8. Part A of Medicare includes "reserve days" if you ever need more than ninety days of inpatient hospital care in any benefit period. How many nonrenewable reserve days are allowed within Medicare? (select only one)

[ ] 25
[ ] 50
[ ] 60
[ ] 90
[ ] 120

9. For inpatient services rendered in 1984, what was the inpatient hospital deductible amount which must be covered by the patient associated with Medicare (Part A) coverage? (select only one)

[ ] $356
[ ] $400
[ ] $250
[ ] $125
[ ] $74

10. For inpatient services rendered in 1984, what was the inpatient hospital co-insurance amount which must be paid for each day of hospitalization associated with Medicare (Part A) coverage? (select only one)

[ ] $30
[ ] $54
[ ] $75
[ ] $120
[ ] $89

11. Which one of the following medical services is <u>not</u> covered at all by CHAMPUS? (select only one)

[ ] Hospital care.
[ ] Durable medical equipment.
[ ] Experimental procedures such as heart and liver transplants.
[ ] Maternity care.
[ ] Ambulance services when medically necessary.

12. Which one of the following medical services is <u>excluded</u> from coverage under Medicare? (select only one)

[ ] Skilled nursing facilities.
[ ] Inpatient hospital care.
[ ] Home health agency care.
[ ] Cosmetic surgery.

DEPARTMENT OF THE ARMY
LETTERMAN ARMY MEDICAL CENTER
PRESIDIO OF SAN FRANCISCO, CALIFORNIA 94129

REPLY TO
ATTENTION OF:

Administrative Resident

Retiree
Letterman Army Medical Center Service Area
Presidio of San Francisco, CA 94129-6700

Dear Retiree,

Enclosed is a questionnaire focusing on medical benefits/limitations which are part of Medicare and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). We are trying to assess whether the retirees in our service population are receiving satisfactory information concerning their entitlement to medical benefits. My staff and I are committed to the goal of providing the best possible care to our patients and through means such as the enclosed questionnaire, we can gain valuable feedback from our service population which will help us improve our performance.

You were chosen to be a participant in this survey through a random sampling process. Your participation is strictly voluntary and your reply will contain no personal identifying data. I do hope that you will take the few minutes necessary to complete the questionnaire and return it in the enclosed postage paid envelope as soon as possible.

The survey data will be closely analyzed by my staff in an effort to determine how we can best support our eligible beneficiaries. I thank you in advance for your time and interest. Your reply will make a difference.

Sincerely,

FRANK F. LEDFORD, JR.
Major General, MC
Commanding

APPENDIX B

PERCENTAGE OF RESPONDENTS ON THE MILITARY RETIREE HEALTH BENEFITS QUESTIONNAIRE

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espondents)

PERCENTAGE OF RESPONDENTS ON THE MILITARY RETIREE HEALTH BENEFITS QUESTIONNAIRE

Please place an X in the box beside the statement which best answers the question being addressed.

A. How long has it been since your retirement from the military service?

6.5%) [ ] 0-5 years
10.8%) [ ] 5-10 years
17.7%) [ ] 10-15 years
25.8%) [ ] 15-20 years
23.1%) [ ] 20-25 years
3.8%) [ ] 25-30 years
3.8%) [ ] 30-35 years
5.4%) [ ] 35-40 years
3.2%) [ ] Greater than 40 years

B. Do you presently purchase any type of medical insurance (other than Medicare, Part B) to provide additional protection against increasing health care costs?

45.7%) [ ] Yes (If yes, what type?_____)
54.3%) [ ] No

The questions below were formulated to assess your present knowledge base of the medical benefits/limitations which are part of the Medicare and CHAMPUS programs. Please select the single best answer for each question and mark an X in the block corresponding to that one answer.

1. Retirees and their dependents are authorized care in Uniformed Services facilities regardless of their eligibility for Medicare subject to: (select only one)

5.4%) [ ] Demonstrating that they are financially unable to defray the cost of care elsewhere.

20.4%) [ ] Living within a 40-mile radius of the military installation where the health care facility is located.

58.6%) [X] Availability of space and facilities and capabilities of the professional staff.

10.2%) [ ] Meeting the same qualifications which are required for CHAMPUS benefits.

5.4%) No answer.

X-correct answer.

(Percentage of Respondents)

2. If you are eligible for Medicare (Part A) coverage and are a retiree, a survivor, or a dependent of a retiree you are: (select only one)

(33.9%) [ ] Still eligible for CHAMPUS benefits.
(57.0%) [X] Not eligible for CHAMPUS benefits.
(9.1%) No answer.

3. Which one of the following groups of individuals is not eligible for CHAMPUS benefits? (select only one)

(8.6%) [ ] Children of active duty members.
(59.7%) [X] Dependent parents or parents-in-law.
(1.6%) [ ] Spouses of retirees.
(4.8%) [ ] Unremarried widowers and widows of deceased active duty members and deceased retirees.
(11.3%) [ ] Children of retirees.
(14%) No answer.

4. What is the yearly deductible amount which must be paid by the patient or family associated with CHAMPUS medical coverage for outpatient care? (select only one)

(22%) [ ] There is no deductible.
(8.1%) [ ] Yearly deductible of $25 for one person or $50 for a family.
(39.2%) [X] Yearly deductible of $50 for one person or $100 for a family.
(11.8%) [ ] Yearly deductible of $100 for one person or $200 for a family.
(18.8%) No answer

5. Retired military families pay or cost share what percent of CHAMPUS outpatient care costs? (select only one)

(7.5%) [ ] 5 percent
(11.3%) [ ] 10 percent
(3.8%) [ ] 15 percent
(22.6%) [ ] 20 percent
(30.1%) [X] 25 percent
(24.7%) No answer.

6. Medicare is a federal health insurance program for people age 65 or older, people of any age with permanent kidney failure, and certain disabled people. Medicare is divided into two parts, which are: (select only one)

(23.1%) [ ] Outpatient insurance and inpatient insurance.
(51.6%) [X] Hospital insurance and medical insurance.
(7.5%) [ ] Institutional insurance and physician insurance.
(3.8%) [ ] Hospital insurance and community health program insurance.
(14.0%) No answer.

7. Which one of the following services is not covered under either Part A or Part B of Medicare? (select only one)

(4.3%) [ ] Doctor's services.
(3.2%) [ ] Outpatient hospital services.
(22%) [ ] Home health visits.
(58.6%) [X] Domiciliary/custodial care.
(1.1%) [ ] Inpatient hospital care.
(10.8%) No answer.

X-correct answer.

(Percentage of Respondents)

8. Part A of Medicare includes "reserve days" if you ever need more than ninety days of inpatient hospital care in any benefit period. How many nonrenewable reserve days are allowed within Medicare? (select only one)

(9.7%)	[ ] 25	(12.4%)	[ ] 90
(1.6%)	[ ] 50	(12.9%)	[ ] 120
(32.3%)	[X] 60	(31.2%)	No answer

9. For inpatient services rendered in 1984, what was the inpatient hospital deductible amount which must be covered by the patient associated with Medicare (Part A) coverage? (select only one)

(29.6%)	[X] $356	(14%)	[ ] $125
(8.1%)	[ ] $400	(5.9%)	[ ] $74
(12.4%)	[ ] $250	(30.1%)	No answer

10. For inpatient services rendered in 1984, what was the inpatient hospital co-insurance amount which must be paid for each day of hospitalization associated with Medicare (Part A) coverage? (select only one)

(13.4%)	[ ] $30	(10.8%)	[ ] $120
(5.9%)	[ ] $54	(18.3%)	[X] $89
(14.5%)	[ ] $75	(37.1%)	No answer

11. Which one of the following medical services is <u>not</u> covered at all by CHAMPUS? (select only one)

(.5%)	[ ] Hospital care.
(8.6%)	[ ] Durable medical equipment.
(69.4%)	[X] Experimental procedures such as heart and liver transplants.
(2.7%)	[ ] Maternity care.
(1.6%)	[ ] Ambulance services when medically necessary.
(17.2%)	No answer.

12. Which one of the following medical services is <u>excluded</u> from coverage under Medicare? (select only one)

(2.2%)	[ ] Skilled nursing facilities.
(.5%)	[ ] Inpatient hospital care.
(7.0%)	[ ] Home health agency care.
(80.1%)	[ ] Cosmetic surgery.
(10.2%)	No answer.

*-correct answer

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